# 患者財務援助
# Patient Financial Assistance

## A. 醫院或診所地點
## Hospital or Clinic Location

請選擇患者接受或將要接受治療的地點：
Select the location(s) where the patient received or will receive care:

- ☐ Henry Ford (HF) Hospital
- ☐ HF Kingswood Hospital
- ☐ HF Macomb Hospital
- ☐ HF Medical Centers
- ☐ HF Jackson Hospital
- ☐ HF West Bloomfield Hospital
- ☐ HF Wyandotte 或 HF Health Center Brownstown
- ☐ 其他（請注明）：_____
  Other, please specify:

## B. 患者資訊
## Patient Information

請填寫本部分有關接受護理的患者的資訊：
Complete this section about the patient receiving care:

患者姓名：_____
Patient Name:

出生日期 (Date of Birth, DOB)：_____ 醫療記錄號碼：_____
Date of Birth (DOB): Medical Record Number:

社會安全號碼：_____
Social Security Number:

擔保人 ID 號碼：_____
Guarantor ID Number:

## C. 責任方（擔保人）
## Responsible Party (Guarantor)

請填寫本部分有關醫療費用支付人的資訊：
Complete this section about the person paying the medical bill:

責任方姓名（如與 B 部分不同，請填寫）：_____
Responsible Party Name (if different than section B):

與患者的關係：_____
Relationship to Patient:

街道地址：_____
Street Address:

城市、州、郵遞區號、國家：_____
City, State, Zip Code, Country:

辦公電話：_____ 辦公電話：_____
Phone Number: Work Phone Number:

雇主：_____ ☐ 全職 ☐ 兼職
Employer: Full Time Part Time

## D. 健康保險資格驗證
## Health Insurance Eligibility Verification

請對以下每個問題選擇“是”或“否”：
Select 'yes' or 'no' for each of the following questions:

| | | |
|---|---|---|
| 1. 您是否申請過 Medicare 或被其拒絕過？<br>Have you applied or been denied for Medicare? | ☐ 是 Yes | ☐ 否 No |
| a. Medicare A 部分？<br>Medicare Part A? | ☐ 是 Yes | ☐ 否 No |
| b. Medicare B 部分？<br>Medicare Part B? | ☐ 是 Yes | ☐ 否 No |
| c. Medicare C 部分？<br>Medicare Part C? | ☐ 是 Yes | ☐ 否 No |
| 2. 您是否申請過 Medicaid 或被其拒絕過？<br>Have you applied or been denied for Medicaid? | ☐ 是 Yes | ☐ 否 No |
| a. 如果您被拒絕，拒絕時間是否在最近 90 天內？<br>If you were denied, was the denial within the last 90 days? | ☐ 是 Yes | ☐ 否 No |
| 3. 您是否在申請與以下方面相關的援助服務？<br>Are you applying for financial assistance services related to:<br>a. 機動車交通事故 (Motor vehicle accident, MVA)？<br>Motor vehicle accident (MVA)? | ☐ 是 Yes | ☐ 否 No |
| b. 犯罪受害者？<br>Crime victim? | ☐ 是 Yes | ☐ 否 No |
| c. 工傷賠償？<br>Workers compensation? | ☐ 是 Yes | ☐ 否 No |
| d. 其他傷害（例如滑倒和跌倒）？<br>Other injury (for example, slip and fall)? | ☐ 是 Yes | ☐ 否 No |
| 4. 您或您配偶的雇主是否提供團體健康保險？<br>Does your employer or spouse's employer offer group health insurance? | ☐ 是 Yes | ☐ 否 No |
| 5. 您在最近 3 至 6 個月內是否已透過您或您配偶的雇主獲取保險？<br>Did you have coverage in the last 3 to 6 months through your employer or spouse's employer? | ☐ 是 Yes | ☐ 否 No |
| a. 如勾選「是」，您是否可以享受《統一綜合預算調節法案》(Consolidated Omnibus Budget Reconciliation Act, COBRA) 的福利？<br>If yes, is COBRA available to you? | ☐ 是 Yes | ☐ 否 No |

6. 您是否還投保了其他健康保險？
Do you have any other health insurance? ☐ 是 Yes ☐ 否 No

a. 如勾選「是」，請提供保險資訊：
If yes, please provide the insurance information:

7. 您是住在 Henry Ford Health 服務區域內的永久居民嗎？
Are you a permanent resident who lives within the Henry Ford Health service area? ☐ 是 Yes ☐ 否 No

## E. 家庭成員和家庭就業收入
## Household Members and Household Employment Income

請填寫本部分有關患者家庭的資訊：
Complete this section about the patient's household:

您家有幾口人？_____
How many people are in your household?

請列出任何有收入的家庭成員（如有需要，請另附一張紙）：
List any household member who earns an income (attach another sheet if needed):

| 家庭成員姓名<br>Household Member Name | 與患者的關係<br>Relationship to Patient | 每月總收入（扣稅前）<br>Monthly Gross Income (before deductions) |
|---|---|---|
| | | $ |
| | | $ |
| | | $ |
| | | $ |
| | | $ |
| | 每月總收入：<br>Total Monthly Gross Income: | |

## F. 家庭其他收入
## Household Other Income

如果患者有其他收入來源，請填寫本部分有關患者其他收入的資訊：
Complete this section about the patient's other income if these are other sources of income:

| 其他收入來源<br>Other Income Sources | 每月金額<br>Amount Per Month |
|---|---|
| 子女撫養費/贍養費<br>Child Support/Alimony | $ |
| 家庭寄養、城鎮受託人、教會收入等<br>Foster Care, Township Trustee, Church Income, etc. | $ |

| | |
|---|---|
| 養老金、社會保險、殘疾人社會保險<br>Pension, Social Security, Social Security Disability | $ |
| 房屋出租<br>Rental Property | $ |
| 年金、利息、退休金分配<br>Annuities, Interest, Retirement Distribution | $ |
| 失業補償或工傷賠償<br>Unemployment or Worker's Compensation | $ |
| 其他（請注明）<br>Other (please specify) | $ |
| 其他收入來源總計<br>Total Other Income Sources | $ |

## G. 家庭資產
## Household Assets

如果有家庭資產，請填寫本部分有關患者家庭資產的資訊：
Complete this section about the patient's household assets if these are household assets:

| 資產類型<br>Type of Asset | 總計<br>Total |
|---|---|
| 現金<br>Cash | $ |
| 儲蓄帳戶<br>Savings Account | $ |
| 支票帳戶<br>Checking Account | $ |
| 股票<br>Stocks | $ |
| 債券<br>Bonds | $ |
| 儲蓄債券<br>Savings Bonds | $ |
| 定期存款 (Certificates of Deposit, CD)<br>Certificates of Deposit (CDs) | $ |
| 貨幣市場帳戶<br>Money Market Accounts | $ |
| 共同基金<br>Mutual Funds | $ |
| 信託基金<br>Trusts | $ |
| 總資產<br>Total Assets | $ |

## H. 每月家庭支出
## Monthly Household Expenses

如果有家庭支出，請填寫本部分有關患者家庭支出的資訊：
Complete this section about the patient's household expenses if there are any household expenses:

| 支出類型<br>Type of Expense | 每月金額<br>Amount Per Month |
|---|---|
| 租金<br>Rent | $ |
| 抵押貨款<br>Mortgage | $ |
| 子女撫養費<br>Child Support | $ |
| 生活用品<br>Groceries | $ |
| 養車費用<br>Vehicle Payment | $ |
| 一般費用<br>General Bills | $ |
| | |
| 每月家庭總支出<br>Total Monthly Household Expenses | $ |

## I. 授權聲明
## Authorization

本人特此授權 Henry Ford Health (HFH) 根據 HFH 的政策和程式公開本申請表中的資訊，以確定本人是否有資格獲得援助。本人授權 HFH 在必要時驗證這些資訊，其採用的措施包括但不限於獲得征信機構報告、核實就業情況和/或收入，以及獲取相關證明檔。本人在此申請表中提供的所有資訊及收入證明檔均真實、準確、完整。如果 HFH 在任何時候確定本人提供了虛假或不準確的資訊，則本人所有的財務援助將撤銷，並且本人將負責立即全額支付任何或全部未結清餘額。本人也同意承擔任何部分財務援助折扣後任何應付款項的支付責任。

I hereby authorize the release of the information contained in this application to Henry Ford Health (HFH) for the determination of my eligibility status for financial assistance in accordance with HFH policies and procedures. I authorize HFH to verify this information as necessary, which may include but is not limited to, obtaining a credit bureau report, verifying employment and/or income, and obtaining appropriate supporting documents. All information and income documentation provided by me in this application is true, accurate and complete as shown. If it is determined at any time the information I provided was false or inaccurate, all financial assistance will be reversed, and I will accept responsibility for full and immediate payment of any and all outstanding balances. I also agree to accept payment responsibility for any amount due after any partial financial assistance discounts.

正楷姓名：_____
Print Name:

與患者的關係：_____
Relationship to Patient:

簽名：_____
Signature:

日期：_____
Date:

在交回申請之前，請確認您已填寫本檔並提供處理申請所需的所有適用檔：
Please verify that you have completed this document and provided all applicable documentation needed to process your request before you return your application:

- ☐ 已填妥申請表的所有頁面，包括簽名和日期。
  Completed all pages of application, including signature and date.

- ☐ 已隨附您最近一年的工資和稅單（表 W-2）和雜項收入（表 1099）。
  Attached your most recent year Wage and Tax Statements (Form W-2) and or Miscellaneous Income (Form 1099).

- ☐ 已隨附最近兩個月的工資單，其中包含每位家庭成員年初至今的收入。
  Attached last 2 months of pay stubs with year-to-date earnings for each member of the household.

- ☐ 已隨附您最近一年的聯邦所得稅退稅資訊（表 1040）。
  Attached your Federal Income Tax return for the most recent year (form 1040).

- ☐ 已隨附密西根州駕駛執照或密西根州身分證副本。
  Attached a copy of your Michigan driver's license or Michigan state identification card.

- ☐ 已隨附您最近兩個月的銀行對帳單：支票/存款。
  Attached your last two months of recent bank statements: checking/savings.

- ☐ 已隨附其他收入證明（例如，房租收入等）。
  Attached proof of other income (or example: rental income, etc.)

- ☐ 如果您有醫療保險，則已隨附醫療保險卡副本。
  Attached copies of medical insurance cards if you have coverage.

- ☐ 已隨附 Medicaid 拒絕函副本（如果您已申請並遭到拒絕）。
  Attached a copy of the Medicaid denial letter if you applied and were denied.

請注意，為便於進一步評估您的申請，您可能需要提供一份個人財務需求聲明。
Please note, a statement of personal financial need may be required to further evaluate your application.